CITATION: Julius v. Klukach, 2025 ONSC 6985
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SUPERIOR COURT OF JUSTICE - ONTARIO

RE: JULIUS OHENHEN, Appellant

AND:

JOHN KLUKACH, Respondent

BEFORE: Akazaki J.

COUNSEL: Lisa Leinveer, for the Appellant

Katelyn MacFadyen, for the Respondent

HEARD: November 19, 2025

REASONS FOR DECISION

OVERVIEW

[1] Julius Ohenhen appealed the decision of the Ontario Consent and Capacity Board ("the Board"), dated February 17, 2025. The Board had upheld the finding of Dr. John Klukach that Mr. Ohenhen was incapable of deciding to refuse antipsychotic medication under s. 4 of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A ("the Act"). Mr. Ohenhen contended that the Board had misdirected itself on the second branch of the s. 4 analysis by measuring his ability to appreciate the reasonably foreseeable consequences of a decision to take himself off the medication.

[2] Mr. Ohenhen, now 52, has a criminal record from offences during the 1990's and early 2000's. Upon completion of a sentence for criminal harassment in 2001, he was hospitalized involuntarily under the *Mental Health Act*, R.S.O. 1990, c. M.7, for serious persecutory delusions and schizophrenia, resulting in antisocial behaviour such as threats and aggressions, telephone harassment and compulsive letter writing. In 2007, he pled and was found not criminally responsible ("NCR"). This resulted in a detention order by the Ontario Review Board. By 2015, he was discharged to the community in high-support housing. He received an absolute discharge in 2019.

[3] Since discharge, Mr. Ohenhen has remained stable while on antipsychotic medication. He has grown resistant to the treatment because of the side effects of drowsiness and nausea. He believes he never required the medication to keep him peaceful. He applied to the Board several times to overturn the finding of treatment incapacity, including a previous appeal to this court. Dr. Klukatch has been treating Mr. Ohenhen for four years and testified before

the Board that his patient remained incapable of making treatment decisions. Dr. Klukatch conceded that Mr. Ohenhen could understand the basic information about his treatment, meeting the first part of the test for capacity under s. 4(1). However, the doctor found him incapable of appreciating the reasonably foreseeable consequences of coming off the medication.

[4] The Board's decision consisted mostly of uncontroversial descriptions of its mandate, the statutory burden of proof, the guiding principles for interpreting s. 4 as stated in the Supreme Court of Canada's leading decision in *Starson v. Swayze*, 2003 SCC 32, [2003] 1 SCR 722, and a faithful summary of the evidence at the hearing. The Board then concluded that Mr. Ohenhen lacked the ability to appreciate the consequences of stopping his medication, because:

1. He attributed his criminal past to youth rather than mental illness, contrary to Dr. Klukach's medical opinion.

2. His compliance with the medication regime was motivated by avoidance of police involvement instead of the need to stay on medication to avoid relapse into antisocial behaviour.

[5] These conclusions were consistent with the evidence of the witnesses and the clinical notes and records. Dr. Klukach concluded that mental illness drove Mr. Ohenhen to the obsessive and delusional ideations resulting in his criminal behaviour. Mr. Ohenhen testified that he had stayed on the medication out of fear that his residential carers would call the police, and not because he believed the medication was the reason for his mental stability.

[6] This clash over the patient's acceptance of his mental illness cannot, however, govern the second part of the test for capacity under s. 4(1). The Board is not permitted to determine the patient's incapacity, based on the patient's disagreement with the medical diagnosis and the doctor's opinion that the patient needed to stay medicated. Instead, s. 4(1) of the Act required the Board to determine Mr. Ohenhen's ability to appreciate foreseeable consequences of a treatment decision. The wisdom of changing course against medical advice was not part of the Board's statutory mandate.

[7] The appreciation of the reasonably foreseeable consequences of treatment cessation refers to a patient's openness to the possibility of negative outcomes, even if the patient disagrees with the physician about the likeliness of such outcomes. Mr. Ohenhen's evidence that he planned to reduce the medication before stopping altogether showed he recognized a correlation between the treatment and his symptoms. He also acknowledged the need for medical assistance to carry out his plan, because he could not prescribe or calibrate the dosages. His evidence that he would return to the medication if he suffered a relapse recognized the possibility that his decision could turn out wrong. The Board could not reject or dismiss this evidence, because it exhibited the patients' awareness of the connection between the treatment and his mental health.

[8] The principle of patient autonomy underlying the Act respects the individual's right to hold a view that is contrary to the weight of medical opinion about diagnosis and treatment. The doctor must demonstrate that his patient's mind is closed to the possibility that a decision to stop medication can cause a relapse of antisocial behaviour. A disagreement with the physician over medical etiology of the past behaviour or over the clinical benefits of the medication do not amount to legal grounds for finding incapacity under the second part of the s. 4(1) test. Because the Board decided Mr. Ohenhen's incapacity based on this misinterpretation of the statute, the decision cannot stand.

[9] In granting the appeal and declaring Mr. Ohenhen capable of making treatment decisions, I appreciate the possibility or even the probability that his condition could return with sufficient severity that he loses the ability to appreciate the consequences of refusing to return to the drug regimen. However, capacity is a point-in-time determination. He is currently capable. The Act does not serve as a prophylactic for prevention of anti-social behaviour. Its purpose is not to keep the citizens of Ontario docile or pliable. These purposes inform the remit of Parliament in codifying Canada's criminal law.

[10] I will now set out my reasoning in further detail.

STANDARD OF REVIEW

[11] Subsection 80(1) of the Act provides an appeal of the Board's decision to this court, "on a question of law or fact or both." Under s. 80(10), the court may exercise all the powers of the Board, substitute its opinion for that of the physician or the Board, or refer the issue back to the Board.

[12] The general deferential standard of review of reasonableness for administrative decisions does not apply, if there is a statutory right of appeal. The appellate court reviews questions of law on a correctness standard. Questions of fact and questions of mixed fact and law require the appellant to show the tribunal made a palpable and overriding error, unless there is an extricable error of law: *Canada (Minister of Citizenship and Immigration*) *v. Vavilov*, 2019 SCC 65, [2019] 4 S.C.R. 653, at paras. 16-17 and 36-37.

[13] Major J.'s majority opinion in *Starson* provided guidance on the standard of review, although the organization of this part was confusing. At para. 84, he divided the reviewing judge's reversal of the Board into two conclusions: (1) that the Board's finding of incapacity was unreasonable on the evidence, and (2) that the Board erred in applying the statutory test for capacity.

[14] Labelling the first section, "(1) Standard of Review," he concluded at para. 84 that the Board's determination of capacity was a question of mixed fact and law, because the Board must apply the evidence to the statutory test for capacity. In the absence of an error in law, this question was relatively fact intensive. In the remainder of the section, Major J. agreed with the reviewing judge's conclusion that the Board's determination was unreasonable, because of the absence of evidence supporting the Board's critical findings of (a) the

patient's denial of a mental disorder and (b) of a failure to appreciate the consequences of his decision. This part of the *Starson* analysis logically gravitated to the reasonable standard, because it was essentially a review of the evidence.

[15] I need not consider the effect on the above reasonableness analysis in *Starson* of the more recent shift in *Vavilov* toward harmonizing appellate review of questions of fact and questions of mixed fact and law to the "palpable and overriding error" standard. Mr. Ohenhen's counsel could point to no reviewable failure of the Board in its findings of fact, and I could not discern any. The core issue on this appeal turns on an extricable issue of law in the legal analysis guiding the Board's reasoning. For this, *Starson* continues to provide guidance about the court's task of detecting and extracting an issue of law from the Board's decision.

[16] In para. 109 of *Starson*, Major J. introduced the second section, "(2) The Board's Misapplication of the Capacity Test," with his agreement with the reviewing judge that the Board had *also* misapplied the statutory test for capacity. He then stated that interpretation of the legal standard is a question of law. The reviewing judge owed no deference to the Board on this issue, because of "the broad statutory right of appeal and adjudicative nature of the proceedings." In para. 112, Major J. extracted from the Board's incorrect reasoning that the patient must have lacked the ability to take himself off the medication, if the medication had relieved him from suffering mental illness:

> [T]he Board's reasons indicate that it strayed from its legislative mandate to adjudicate solely upon the patient's capacity. The Board stated at the outset of its reasons that "it viewed with great sadness the current situation of the patient" (p. 15), and later noted that "his life has been devastated by his mental disorder" (p. 16). Putting aside the fact that the respondent entirely disagreed with those statements, the tenor of the comments indicate that the Board misunderstood its prescribed function. The Board's sole task was to determine the patient's mental capacity. The wisdom of Professor Starson's treatment decision is irrelevant to that determination. If Professor Starson is capable, he is fully entitled to make a decision that the Board, or other reasonable persons, may perceive as foolish. The Board improperly allowed its own conception of Professor Starson's best interests to influence its finding of incapacity.

[17] Questions on appeal often involve categorical gradations between deference to factual determinations and no deference to legal conclusions. The right of appeal also distinguishes this case from the more general deference to administrative tribunals on judicial review. An appeal is not an application for judicial review. Major J.'s reference to *Canada (Director of Investigation and Research) v. Southam Inc.*, [1997] 1 SCR 748, at paras. 35-37, and the same court's guidance in *Housen v. Nikolaisen*, [2002] 2 SCR 235, at paras. 9 and 34, are instructive in explaining how the Board's misapplication of the test for capacity in *Starson* attracted a correctness standard of review. Even when the issue appears to mix fact and law, an outcome readily traceable to an error of law extricated from the legal and factual matrix requires review on a correctness standard.

[18] Extricating the legal issue from adjudicative reasoning involving clinical evidence of mental illness remains a protean task. In *Starson*, at paras. 111-112, Major J. agreed with two legal errors identified by the reviewing judge. First, the Board based its conclusions on the patient's failure to appreciate the consequences of the decision to stop treatment because of the refusal to agree with the medical recommendation. This refusal did not amount to evidence that the mental disorder prevented him from being *able* to appreciate the consequences, as provided in s. 4(1). Second, the Board strayed from its legislative mandate by relying on the wisdom of the patient's decision and his best interests, instead of the narrow issue of capacity.

[19] Thus, the adjudicative attempt to answer the wrong or irrelevant question, relative to the statutory test for capacity, signifies an error of law despite the appearance of a question of mixed fact and law. Where there is no apparent error in the Board's appreciation of the facts, a faulty framework for analysis could denote extricable error in the conclusion of the patient's current inability to appreciate consequences of a proposed treatment decision.

[20] I will therefore consider the Board's framework of statutory reasoning behind its conclusion of Mr. Ohenhen's incapacity according to the second part of the s. 4(1) analysis. On this point, the Board's decision is subject to a correctness standard.

SECOND PART OF THE S. 4 LEGAL ANALYSIS: APPRECIATION OF REASONABLY FORESEEABLE CONSEQUENCES OF A TREATMENT DECISION

[21] Subsection 4(2) of the Act codifies the patient's right to be presumed capable to consent and to withhold consent to medical treatment. Under para. 1(c), a purpose of the Act is to enhance patient autonomy. The physician and Board must inquire into the patient's capacity under s. 4(1) to appreciate the parameters of the treatment: its nature and purpose, foreseeable risks and benefits, the available alternatives, and the expected consequences of declining treatment. The patient need not weigh or value the information in the way the physician does: *Starson*, at para. 80. The decision to consent and to refuse consent to treatment command the same legal protection. In practice, persons possess more autonomy to refuse than to demand treatment, because medical ethics and malpractice law will stop physicians from carrying out a procedure contrary to the standard of care. The right to refuse consent allows the patient to stand against medical opinion, even if the decision may be foolish: *Starson*, at para. 76.

[22] The Board's determination of Mr. Ohenhen's incapacity contained the appropriate language of inability to appreciate the consequences of stopping his medication. However, neither his disagreement with Dr. Klukach of the cause of his criminal past nor his non-medical motives for compliance with the medication regime addressed the question whether Mr. Ohenhen possessed the capacity to appreciate that discontinuing the medication could cause his antisocial behaviour to reappear. In fact, the Board exceeded its authority by finding him incapable based on his disagreement with medical opinion and

not on his ability to foresee the need to revert to medication if Dr. Klukach's opinion turned out to be correct.

[23] In his testimony at the Board hearing, Mr. Ohenhen attributed his criminal past to youthful immaturity and not to schizophrenia. He also stated that he had played the justice system by pleading NCR to avoid a second term of incarceration. It was reasonable for the Board to accept Dr. Klukach's diagnosis and opinion of a causal link over Mr. Ohenhen's lay opinion. I also recognize the Board having to contend with the potential paradox created by Mr. Ohenhen's evidence essentially that he had lied to the court about his criminal conduct having been driven by a mental disorder. His belief in a past lie about schizophrenia could be evidence either of a present delusion or a lie about having lied.

[24] Assuming he was wrong or untruthful, Mr. Ohenhen's incorrect denial of the link between mental illness and his criminal conduct did not negate his awareness of the criminality of the offences he had committed. His denial of a risk of reoffending because he was older and wiser inherently conceded that he had harmed his victims. This reasoning included an appreciation that he did not want return to the harmful behaviour, if that should result from his cessation of the treatment.

[25] The Board found that Mr. Ohenhen's motive for taking the medication was to avoid police involvement and to stay out of jail, and not because he recognized the benefit to taking the medication. The perception of a speedy track back to incarceration is not an illegitimate motive for a Black individual in Ontario society: *R. v. Morris*, 2021 ONCA 680, 159 O.R. (3d) 641, at paras. 39-42. His consent to medical treatment should be free from such coercion.

[26] Even so, the desire to remain on the right side of the law indicated an appreciation of the potential consequences of his treatment decision. The Board could only have construed that motive as lack of appreciation of consequences by concluding that Mr. Ohenhen failed to heed the medical opinion that he avoided law enforcement and incarceration because of the medication. This meant the only way he could have persuaded the Board of his decision-making ability was to accept the medical opinion. The Board's reasoning may have made sense from a clinical best-interests perspective, but it departed from its statutory authority under the second branch of the s. 4(1) test to gauge ability to appreciate the foreseeable consequences of his treatment decision.

[27] Mr. Ohenhen testified that his plan was to reduce the dosage of the medication and eventually to stop it. When asked what he would do if his symptoms returned, he stated he would resume taking the medication. The Board rejected this evidence on the basis that "his overall testimony suggested that he never accepted that his past offences were the result of a psychotic illness." This rejection showed how the entire reasoning was guided by this irrelevant consideration of Mr. Ohenhen's refusal to accept mental illness as the cause of offences he committed over 20 years ago. Rather, both elements of his uncontradicted testimony, that he planned to titrate the reduction of dosage and to restore the regimen if his symptoms relapsed, demonstrated ability to understand a connection

between the medication and his mental condition, even if he disagreed with the necessity of medication in his case.

[28] This evidence was not subject to a standard credibility analysis of the kind the Board engaged in its decision, by weighing it against his refusal to accept the historical link with his criminal offences. Even if Mr. Ohenhen was lying when outlining his plan of gradual elimination of the medicine and when vowing to return to it if the experiment failed, his ability to describe the process meant he possessed the ability to grasp the interaction between the treatment and his ability to avoid unnecessary conflict with other members of society. His denial of the medication's value did not amount to an insistence on immediate cessation without the possibility of return.

[29] The fact that a symptomatic Julius Ohenhen could later lack the ability to change course may and probably will be a practical clinical concern. Dr. Klukach and the staff at Mr. Ohenhen's residence observed some relapse during Dr. Klukach's attempt to wean Mr. Ohenhen off the medication. Mr. Ohenhen blamed the conflict, described as a dispute over TV programming, on a member of staff who no longer works there. Dr. Klukach also observed that Mr. Ohenhen resumed obsessive letter-writing, to persons whose addresses were incorrect, with the result that the letters were returned by Canada Post.

[30] Dr. Klukach reasonably concluded that these incidents meant the experiment had failed and was contrary to his patient's and his residence staff's best interests. However, he and the Board incorrectly concluded that the evidence of potential relapse warranted depriving Mr. Ohenhen of the choice of the next step. Because the medication is prescribed and injected subcutaneously, the only reasonable interpretation of Mr. Ohenhen's evidence would be that he would reduce the dosage under medical supervision.

[31] The institution's desire to maintain peace, order, and well-being was not a policy goal of the Act. A desire to subdue Mr. Ohenhen's nuisance behaviour, such as conflict over the choice of TV programmes or in letters written to obsolete addresses, was a reasonable concern held by the doctor and other staff. However, it was invalid as a justification for depriving him of his bodily autonomy or for maintaining his drugged condition as the default state of being. The Act's purpose did not extend to control of behaviour. Rather, the physician and Board's duty was to consider whether the patient's condition and behaviour warranted the extreme measure of silencing the patient's voice in matters concerning his own body.

[32] Ultimately, the Board interpreted Mr. Ohenhen's desire to make the basic consent-to-treatment decisions, and to keep trying, as irrational, because of his failure to agree that the medication was beneficial. The Act protects the right of all Ontarians with medical conditions, both physical and mental, to manage their treatment and to hope for a better outcome, provided they can understand medical advice and appreciate the odds that their decisions might be unwise. Mr. Ohenhen understood that in the opinion of the clinicians, social workers and law enforcement, there was a link between his medication and risk of reoffending. This understanding denoted his ability to appreciate the consequences of stopping his medication.

[33] Neither Mr. Ohenhen's rationale for pleading NCR nor his compliance with institutional recommendations to stay medicated should have been the subject of a weighing of credibility between the doctor's opinion and the patient's. True or not, valid or not, the key elements of Mr. Ohenhen's evidence and position clearly demonstrated awareness of the risk analysis employed by Dr. Klukach and the staff at Mr. Ohenhen's residence. The Board's function was not to conclude that Mr. Ohenhen's plan for taking himself off the medication was likely to fail. The second-branch capacity test under s. 4(1) of the Act required it to assess whether he could appreciate that it could fail.

[34] Finally, the Board's focus on the cause of Mr. Ohenhen's criminal behaviour twenty years ago and on his denial of the correlation between the reduction of dosage and the resurfacing of negative conduct denied him of the right to have his capacity determined while his condition was stable. The patient's capacity can fluctuate over time. The Board's decision must be specific to his capacity at the time of the hearing: *Starson*, at paras. 118-119. This temporal aspect of the s. 4 framework arises from the present tense in the clause, "if the person *is* … able to appreciate the reasonably foreseeable consequences of a decision." Neither the patient's belief regarding how he ended up in the mental health system nor the likelihood that treatment cessation will diminish capacity were relevant to his current ability to size up the risks and benefits of coming off the medication.

[35] The statute therefore contemplated that a medicated individual can be capable of appreciating consequences because of the stability provided by the medication. Some patients will not possess this ability despite medication, such as a person whose behaviour or impulses might be sedated but who remains unable to reason between treatment benefits and relapse without treatment. The Board's duty was to examine the evidence of Mr. Ohenhen's ability to appreciate the potential cause and effect of the treatment decision at the time of the hearing, while medicated and stable.

[36] Consenting to treatment to avoid triggering institutional responses is a kind of vitiation of consent that the Act intended to eliminate. A patient is not required to describe his mental condition as an illness, or to agree with the medical opinion of the cause of the condition. Canadian law of consent requires freedom from institutional constraint, compulsion, or favour. If the condition results in an inability to recognize that he is affected by its manifestations, the inability to apply the clinical information will render him unable to appreciate the consequences of a decision to cease treatment: *Starson*, at para. 79.

[37] Instead of assessing his capacity at the time of the hearing, when he exhibited a good measure of mental clarity while under medication, the Board appeared to consider that Mr. Ohenhen could lack the ability to appreciate the benefits of returning to the medication regime, once his mental condition worsened. If that were to occur, his physician could re-evaluate Mr. Ohenhen's capacity based on the patient's condition. I appreciate this process could lead to a cycle of repeated attempts to find a compromise between his current level of medication and a tolerable amount of antisocial behaviour. However, the court's statutory jurisdiction on the appeal is coterminous with the Board's: capacity to consent to treatment or to refuse it is the only issue. The negotiation of steps during treatment must be left as a matter between the patient and his physician.

CONCLUSION

[38] The appeal is granted. The decision of the Board confirming the finding of incapacity shall be set aside, and Mr. Ohenhen is declared capable of consenting to treatment. There is no need to remit the case for a rehearing, because the patient's evidence of the plans for reduction of the doses prior to stopping treatment and for return to treatment if the cessation plan failed both proved unassailably that he appreciated the existence of an adverse consequence to his decision. That said, Mr. Ohenhen should not consider this decision a clean bill of health. Having a say in one's treatment is not grounds to dismiss sound medical opinion with his best interests front of mind. To avoid the adverse consequences of police involvement and incarceration, I encourage him to continue to work with his doctor and the residential staff to devise strategies to prevent a relapse of his past behaviour.

[39] Mr. Ohenhen's notice of appeal contained a request for costs, but the factum did not. If the matter of costs cannot be settled, counsel may approach my judicial assistant with a schedule for exchange of submissions.

Akazaki J.

Date: December 12, 2025